# Worker's Compensation Identification Form

This form is to be completed when an employee has lost work time of 3 days or more due to an on-the-job illness or injury.

Employee's Name: _____
Social Security Number: _____
Dist/Sect: _____ Gang: _____
Title: _____ Work Loc. _____

Briefly describe the accident/incident which caused the absence:

_____
_____
_____
_____

Briefly describe the nature of the illness/injury:

_____
_____
_____
_____

Prepared by:

_____
Name

_____
Title

_____
Date